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|--|--|-------------|--|--|--|--|--|
| | | FOR OFF USE | | | | | |
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LL I

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---------------------------------------|---|-------------------------------------|--------------------------------|--------------------------------|--------------------------------------|---------------------------------|---------------------------------|--------------------------------------|--------------------------------------|--|---|--|--|--|--|--|--------------------------------|--|--|--------------------------------------|--|---|---|-----------------------------|---|----------------------|------------------------------------|-----------------------------|------------------------------|-----------------------------|---|
| <p>I. IDPH Facility ID Number: <u>0041699</u></p> <p>Facility Name: <u>HERITAGE MANOR-SPRINGFIELD</u></p> <p>Address: <u>900 N RUTLEDGE</u> <u>SPRINGFIELD</u> <u>61701</u> Number City Zip Code</p> <p>County: <u>SANGAMON</u></p> <p>Telephone Number: <u>(217) 789-0930</u> Fax # ()</p> <p>IDPA ID Number: <u>371359387001</u></p> <p>Date of Initial License for Current Owners: <u>09/01/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>CRAIG L. ATER</u> Telephone Number: <u>(309) 823-7135</u></p> | <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input checked="" type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | IRS Exemption Code _____ | <input type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | <input checked="" type="checkbox"/> "Sub-S" Corp. | | | <input type="checkbox"/> Limited Liability Co. | | | <input type="checkbox"/> Trust | | | <input type="checkbox"/> Other _____ | | <p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>CRAIG L. ATER</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Title) <u>SENIOR V.P. FINANCE</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) <u>(309) 823-7135</u> Fax # () _____</td> </tr> </table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p> | Officer or Administrator of Provider | (Signed) _____ (Date) _____ | (Type or Print Name) <u>CRAIG L. ATER</u> | Paid Preparer | (Title) <u>SENIOR V.P. FINANCE</u> | (Signed) _____ (Date) _____ | (Print Name and Title) _____ | (Firm Name & Address) _____ | (Telephone) <u>(309) 823-7135</u> Fax # () _____ |
| <input type="checkbox"/> VOLUNTARY, NON-PROFIT | <input checked="" type="checkbox"/> PROPRIETARY | <input type="checkbox"/> GOVERNMENTAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Charitable Corp. | <input type="checkbox"/> Individual | <input type="checkbox"/> State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Trust | <input type="checkbox"/> Partnership | <input type="checkbox"/> County | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IRS Exemption Code _____ | <input type="checkbox"/> Corporation | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input checked="" type="checkbox"/> "Sub-S" Corp. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Limited Liability Co. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Trust | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Officer or Administrator of Provider | (Signed) _____ (Date) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Type or Print Name) <u>CRAIG L. ATER</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paid Preparer | (Title) <u>SENIOR V.P. FINANCE</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Signed) _____ (Date) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Print Name and Title) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Firm Name & Address) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | (Telephone) <u>(309) 823-7135</u> Fax # () _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD# 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

| | 1 | 2 | 3 | 4 | |
|---|--|-----------------------------|---------------------------------|--|---|
| | Beds at Beginning of Report Period | Licensure Level of Care | Beds at End of Report Period | Licensed Bed Days During Report Period | |
| 1 | <u>176</u> | Skilled (SNF) | <u>176</u> | <u>64,240</u> | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | <u>0</u> | Intermediate (ICF) | <u>0</u> | <u>0</u> | 3 |
| 4 | | Intermediate/DD | | | 4 |
| 5 | <u>0</u> | Sheltered Care (SC) | <u>0</u> | <u>0</u> | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | <u>176</u> | TOTALS | <u>176</u> | <u>64,240</u> | 7 |

B. Census-For the entire report period.

| | 1 | 2 | 3 | 4 | 5 | |
|----|---------------|---|---------------|--------------|---------------|----|
| | Level of Care | Patient Days by Level of Care and Primary Source of Payment | | | | |
| | | Public Aid Recipient | Private Pay | Other | Total | |
| 8 | SNF | <u>30,995</u> | <u>18,511</u> | <u>6,762</u> | <u>56,268</u> | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | | | | | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | <u>0</u> | <u>0</u> | <u>0</u> | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | <u>30,995</u> | <u>18,511</u> | <u>6,762</u> | <u>56,268</u> | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.59%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1996

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 1996 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 6,762Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCUAL ☐ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

| | G/L | RECAP CENSUS | DIFF |
|--------------|-------|--------------|------|
| PP | 18661 | 18661 | 0 |
| IPA | 31245 | 31245 | 0 |
| medicare | 6762 | 6762 | 0 |
| | 56668 | 56668 | |
| IPA BEDHOLDS | 250 | | |
| PP BEDHOLDS | 150 | | |
| PP CONVERS | 0 | | |

STATE OF ILLINOIS

Page 3

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

0041699

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

| | Operating Expenses | Costs Per General Ledger | | | | Reclass- ification 5 | Reclassified Total 6 | Adjust- ments 7 | Adjusted Total 8 | FOR OHF USE ONLY | | |
|-----|--|--------------------------|---------------|------------|------------|----------------------------|----------------------------|-----------------------|------------------------|------------------|----|-----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 | |
| | A. General Services | | | | | | | | | | | |
| 1 | Dietary | 356,357 | 16,876 | 0 | 373,233 | | 373,233 | 5,440 | 378,673 | | | 1 |
| 2 | Food Purchase | | 194,248 | | 194,248 | | 194,248 | (1,010) | 193,238 | | | 2 |
| 3 | Housekeeping | 164,623 | 38,613 | | 203,236 | | 203,236 | 0 | 203,236 | | | 3 |
| 4 | Laundry | 103,076 | 23,712 | | 126,788 | | 126,788 | 0 | 126,788 | | | 4 |
| 5 | Heat and Other Utilities | | | 184,451 | 184,451 | | 184,451 | 2,215 | 186,666 | | | 5 |
| 6 | Maintenance | 153,941 | 65,108 | 45,860 | 264,909 | | 264,909 | 17,451 | 282,360 | | | 6 |
| 7 | Other (specify):* | | | | | | | 0 | | | | 7 |
| 8 | TOTAL General Services | 777,997 | 338,557 | 230,311 | 1,346,865 | | 1,346,865 | 24,096 | 1,370,961 | | | 8 |
| | B. Health Care and Programs | | | | | | | | | | | |
| 9 | Medical Director | | | 15,600 | 15,600 | | 15,600 | 0 | 15,600 | | | 9 |
| 10 | Nursing and Medical Records | 2,592,610 | 192,710 | 54,317 | 2,839,637 | | 2,839,637 | 0 | 2,839,637 | | | 10 |
| 10a | Therapy | | 469,604 | 280,182 | 749,786 | (674,052) | 75,734 | 312,153 | 387,887 | | | 10a |
| 11 | Activities | 85,192 | 3,955 | 1,282 | 90,429 | | 90,429 | 0 | 90,429 | | | 11 |
| 12 | Social Services | 79,114 | 2,813 | 2,368 | 84,295 | | 84,295 | 0 | 84,295 | | | 12 |
| 13 | Nurse Aide Training | 0 | 671 | | 671 | | 671 | 3,253 | 3,924 | | | 13 |
| 14 | Program Transportation | | | | | | | 0 | | | | 14 |
| 15 | Other (specify):* | | | | | | | 0 | | | | 15 |
| 16 | | 2,756,916 | 669,753 | 353,749 | 3,780,418 | (674,052) | 3,106,366 | 315,406 | 3,421,772 | | | 16 |
| | C. General Administration | | | | | | | | | | | |
| 17 | Administrative | 63,939 | | | 63,939 | | 63,939 | 48,223 | 112,162 | | | 17 |
| 18 | Directors Fees | | | | | | | 7,551 | 7,551 | | | 18 |
| 19 | Professional Services | | | 353,762 | 353,762 | | 353,762 | (322,536) | 31,226 | | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 126,526 | 126,526 | (96,360) | 30,166 | (1,704) | 28,462 | | | 20 |
| 21 | Clerical & General Office Expenses | 213,516 | 30,344 | 34,172 | 278,032 | | 278,032 | 261,838 | 539,870 | | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 545,910 | 545,910 | | 545,910 | 37,167 | 583,077 | | | 22 |
| 23 | Inservice Training & Education | | | 1,135 | 1,135 | | 1,135 | 864 | 1,999 | | | 23 |
| 24 | Travel and Seminar | | | 7,426 | 7,426 | | 7,426 | (5,427) | 1,999 | | | 24 |
| 25 | Other Admin. Staff Transportation | | | | | | | 0 | | | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 50,694 | 50,694 | | 50,694 | 2,674 | 53,368 | | | 26 |
| 27 | Other (specify):* | | | 45,021 | 45,021 | | 45,021 | (44,968) | 53 | | | 27 |
| 28 | TOTAL General Administration | 277,455 | 30,344 | 1,164,646 | 1,472,445 | (96,360) | 1,376,085 | (16,318) | 1,359,767 | | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 3,812,368 | 1,038,654 | 1,748,706 | 6,599,728 | (770,412) | 5,829,316 | 323,184 | 6,152,500 | | | 29 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD** # **0041699** Report Period Beginning: **01/01/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (continued)

| | Capital Expense | Cost Per General Ledger | | | | Reclass- ification | Reclassified Total | Adjust- ments | Adjusted Total | FOR OHF USE ONLY | | |
|----|---|-------------------------|-----------|-----------|-----------|-----------------------|-----------------------|------------------|-------------------|------------------|----|----|
| | | Salary/Wage | Supplies | Other | Total | | | | | 9 | 10 | |
| | D. Ownership | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | | |
| 30 | Depreciation | | | 213,690 | 213,690 | | 213,690 | 11,730 | 225,420 | | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | | | | | 0 | | | | 31 |
| 32 | Interest | | | 172,021 | 172,021 | | 172,021 | (14,415) | 157,606 | | | 32 |
| 33 | Real Estate Taxes | | | 104,972 | 104,972 | | 104,972 | 0 | 104,972 | | | 33 |
| 34 | Rent-Facility & Grounds | | | 0 | | | | 12,119 | 12,119 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 2,404 | 2,404 | | 2,404 | 26,421 | 28,825 | | | 35 |
| 36 | Other (specify):* Goodwill | | | 40,062 | 40,062 | | 40,062 | (40,062) | | | | 36 |
| 37 | TOTAL Ownership | | | 533,149 | 533,149 | | 533,149 | (4,207) | 528,942 | | | 37 |
| | Ancillary Expense | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | 0 | | | | 38 |
| 39 | Ancillary Service Centers | | | | | 674,052 | 674,052 | 0 | 674,052 | | | 39 |
| 40 | Barber and Beauty Shops | 0 | 0 | 0 | | | | 0 | | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | 0 | | | | 41 |
| 42 | Provider Participation Fee | | | | | 96,360 | 96,360 | 0 | 96,360 | | | 42 |
| 43 | Other (specify):* | | | | | | | 0 | | | | 43 |
| 44 | TOTAL Special Cost Centers | | | | | 770,412 | 770,412 | | 770,412 | | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 3,812,368 | 1,038,654 | 2,281,855 | 7,132,877 | 0 | 7,132,877 | 318,977 | 7,451,854 | | | 45 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD** # **0041699** STATE OF ILLINOIS Report Period Beginning: **01/01/01** Ending: **12/31/01** Page 5
VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

| | | 1 Amount | 2 Refer- ence | 3 OHF USE ONLY | |
|----|---|--------------|---------------------|----------------------|----|
| | NON-ALLOWABLE EXPENSES | | | | |
| 1 | Day Care | \$ | | \$ | 1 |
| 2 | Other Care for Outpatients | | | | 2 |
| 3 | Governmental Sponsored Special Programs | | | | 3 |
| 4 | Non-Patient Meals | | | | 4 |
| 5 | Telephone, TV & Radio in Resident Rooms | 311 | 35 | | 5 |
| 6 | Rented Facility Space | (383) | 34 | | 6 |
| 7 | Sale of Supplies to Non-Patients | | | | 7 |
| 8 | Laundry for Non-Patients | | | | 8 |
| 9 | Non-Straightline Depreciation | 0 | 30 | | 9 |
| 10 | Interest and Other Investment Income | (14,265) | 32 | | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds | | | | 11 |
| 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 | Sales Tax | (1,010) | 2 | | 13 |
| 14 | Non-Care Related Interest | | 32 | | 14 |
| 15 | Non-Care Related Owner's Transactions | 0 | 33 | | 15 |
| 16 | Personal Expenses (Including Transportation) | | 24 | | 16 |
| 17 | Non-Care Related Fees | (881) | 20 | | 17 |
| 18 | Fines and Penalties | | | | 18 |
| 19 | Entertainment | (15,565) | 24 | | 19 |
| 20 | Contributions | 0 | 27 | | 20 |
| 21 | Owner or Key-Man Insurance | | | | 21 |
| 22 | Special Legal Fees & Legal Retainers | (313) | 19 | | 22 |
| 23 | Malpractice Insurance for Individuals | | | | 23 |
| 24 | Bad Debt | (44,968) | 27 | | 24 |
| 25 | Fund Raising, Advertising and Promotional | (7,940) | 20 | | 25 |
| 26 | Income Taxes and Illinois Personal Property Replacement Tax | | | | 26 |
| 27 | Nurse Aide Training for Non-Employees | (562) | 23 | | 27 |
| 28 | Yellow Page Advertising | | | | 28 |
| 29 | Other-Attach Schedule <u>Goodwill</u> | (40,062) | 36 | | 29 |
| 30 | SUBTOTAL (A): (Sum of lines 1-29) | \$ (125,638) | | \$ | 30 |

| OHF USE ONLY | | | | | | | |
|--------------|--|----|----|----|----|--|--|
| 48 | | 49 | 50 | 51 | 52 | | |

Print Preview

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

| | | 1 Amount | 2 Reference | |
|----|--|-------------|----------------|----|
| 31 | Non-Paid Workers-Attach Schedule* | \$ | | 31 |
| 32 | Donated Goods-Attach Schedule* | | | 32 |
| 33 | Amortization of Organization & Pre-Operating Expense | | | 33 |
| 34 | Adjustments for Related Organization Costs (Schedule VII) | 444,615 | | 34 |
| 35 | Other- Attach Schedule | | | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS | \$ 444,615 | | 36 |
| 37 | TOTAL ADJUSTMENTS (A) and (B)) | \$ 318,977 | | 37 |

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

| | | 1 Yes | 2 No | 3 Amount | 4 Reference | |
|----|--|----------|---------|-------------|----------------|----|
| 38 | Medically Necessary Transport. | | | \$ | | 38 |
| 39 | | | | | | 39 |
| 40 | Gift and Coffee Shops | | | | | 40 |
| 41 | Barber and Beauty Shops | | | | | 41 |
| 42 | Laboratory and Radiology | | | | | 42 |
| 43 | Prescription Drugs | | | | | 43 |
| 44 | Exceptional Care Program | | | | | 44 |
| 45 | Other-Attach Schedule | | | | | 45 |
| 46 | Other-Attach Schedule | | | | | 46 |
| 47 | TOTAL (C): (sum of lines 38-46) | | | \$ | | 47 |

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

0041699 Report Period Beginning:

01/01/01

Ending:

Summary A

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

| | Operating Expenses | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|-----|---|-----------------|-----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--|-----|
| | A. General Services | | | | | | | | | | | | | |
| 1 | Dietary | 0 | 0 | 5,440 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,440 | 1 |
| 2 | Food Purchase | (1,010) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,010) | 2 |
| 3 | Housekeeping | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| 4 | Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| 5 | Heat and Other Utilities | 0 | 0 | 2,215 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,215 | 5 |
| 6 | Maintenance | 0 | 0 | 17,451 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17,451 | 6 |
| 7 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| 8 | TOTAL General Services | (1,010) | 0 | 25,106 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24,096 | 8 |
| | B. Health Care and Programs | | | | | | | | | | | | | |
| 9 | Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| 10 | Nursing and Medical Records | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| 10a | Therapy | 0 | 118,302 | 0 | 0 | 193,851 | 0 | 0 | 0 | 0 | 0 | 0 | 312,153 | 10a |
| 11 | Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 12 | Social Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| 13 | Nurse Aide Training | 0 | 0 | 3,253 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,253 | 13 |
| 14 | Program Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| 15 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 |
| 16 | TOTAL Health Care and Programs | 0 | 118,302 | 3,253 | 0 | 193,851 | 0 | 0 | 0 | 0 | 0 | 0 | 315,406 | 16 |
| | C. General Administration | | | | | | | | | | | | | |
| 17 | Administrative | 0 | 0 | 48,223 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 48,223 | 17 |
| 18 | Directors Fees | 0 | 0 | 7,551 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7,551 | 18 |
| 19 | Professional Services | (313) | 0 | 18,517 | 0 | (340,740) | 0 | 0 | 0 | 0 | 0 | 0 | (322,536) | 19 |
| 20 | Fees, Subscriptions & Promotions | (8,821) | 0 | 7,117 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,704) | 20 |
| 21 | Clerical & General Office Expenses | 0 | 0 | 261,838 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 261,838 | 21 |
| 22 | Employee Benefits & Payroll Taxes | 0 | 0 | 37,167 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 37,167 | 22 |
| 23 | Inservice Training & Education | (562) | 0 | 1,426 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 864 | 23 |
| 24 | Travel and Seminar | (15,565) | 0 | 10,138 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (5,427) | 24 |
| 25 | Other Admin. Staff Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | 0 | 0 | 2,674 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,674 | 26 |
| 27 | Other (specify):* | (44,968) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (44,968) | 27 |
| 28 | TOTAL General Administration | (70,229) | 0 | 394,651 | 0 | (340,740) | 0 | 0 | 0 | 0 | 0 | 0 | (16,318) | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8,16 & 28) | (71,239) | 118,302 | 423,010 | 0 | (146,889) | 0 | 0 | 0 | 0 | 0 | 0 | 323,184 | 29 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

0041699

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

| | Capital Expense | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|----|------------------------------------|-----------------|-----------|------------|---------------|------------|------------|------------|------------|------------|------------|------------|--|-----------|
| | D. Ownership | | | | | | | | | | | | | |
| 30 | Depreciation | 0 | 0 | 0 | 11,730 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11,730 | 30 |
| 31 | Amortization of Pre-Op. & Org. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| 32 | Interest | (14,265) | 0 | 0 | (150) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (14,415) | 32 |
| 33 | Real Estate Taxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| 34 | Rent-Facility & Grounds | (383) | 0 | 0 | 12,502 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12,119 | 34 |
| 35 | Rent-Equipment & Vehicles | 311 | 0 | 0 | 26,110 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 26,421 | 35 |
| 36 | Other (specify):* | (40,062) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (40,062) | 36 |
| 37 | TOTAL Ownership | (54,399) | 0 | 0 | 50,192 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (4,207) | 37 |
| | Ancillary Expense | | | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| 39 | Ancillary Service Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| 40 | Barber and Beauty Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 |
| 41 | Coffee and Gift Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 41 |
| 42 | Provider Participation Fee | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 42 |
| 43 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43 |
| 44 | TOTAL Special Cost Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 44 |
| | GRAND TOTAL COST | | | | | | | | | | | | | |
| 45 | (sum of lines 29, 37 & 44) | (125,638) | 118,302 | 423,010 | 50,192 | (146,889) | 0 | 0 | 0 | 0 | 0 | 0 | 318,977 | 45 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

VII. RELATED PARTIES

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes cost

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

| The instructions for accounting items are provided in this form. | | | | | | |
|--|------|----------------------------|----------------------------|----------------------------------|------------------------|---|
| Schedule A | Line | A - Cost or Service Amount | B - Cost or Service Amount | C - Cost or Related Organization | | D - Difference Adjustments for Related Organization Costs (in dollars) |
| | | | | Cost or Service Amount | Cost or Service Amount | |
| | 1 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 2 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 3 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 4 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 5 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 6 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 7 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 8 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 9 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 10 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 11 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 12 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 13 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 14 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 15 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 16 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 17 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 18 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 19 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 20 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 21 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 22 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 23 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 24 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 25 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 26 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 27 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 28 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 29 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 30 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 31 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 32 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 33 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 34 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 35 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 36 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 37 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 38 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 39 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 40 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 41 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 42 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 43 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 44 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 45 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 46 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 47 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 48 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 49 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 50 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 51 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 52 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 53 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 54 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 55 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 56 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 57 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 58 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 59 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 60 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 61 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 62 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 63 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 64 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 65 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 66 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 67 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 68 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 69 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 70 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 71 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 72 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 73 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 74 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 75 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 76 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 77 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 78 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 79 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 80 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 81 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 82 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 83 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 84 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 85 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 86 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 87 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 88 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 89 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 90 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 91 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 92 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 93 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 94 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 95 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 96 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 97 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 98 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 99 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 100 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 101 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 102 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 103 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 104 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 105 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 106 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 107 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 108 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 109 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 110 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 111 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 112 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 113 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 114 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 115 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 116 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 117 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 118 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 119 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 120 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 121 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 122 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 123 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 124 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 125 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 126 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 127 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 128 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 129 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 130 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 131 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 132 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 133 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 134 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 135 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 136 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 137 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 138 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 139 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 140 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 141 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 142 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 143 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 144 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 145 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 146 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 147 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 148 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 149 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 150 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 151 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 152 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 153 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 154 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 155 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 156 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 157 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 158 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 159 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 160 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 161 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 162 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 163 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 164 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 165 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 166 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 167 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 168 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 169 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 170 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 171 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 172 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 173 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 174 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 175 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 176 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 177 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 178 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | 179 | 100.00 | 100.00 | 100.00 | 100.00 | 0.00 |
| | | | | | | |

Sam 6

118302

Print Preview

^a Total must agree with the amount recorded on Line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6L, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6L, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6L, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

[illegible]

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6A

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: | |
|------------|-------|---------------------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 1 Dietary | \$ | Heritage Enterprises, Inc. | 100.00% | \$ 5,440 | \$ 5,440 | 15 |
| 16 | V | 2 Food Purchase | | | | 0 | | 16 |
| 17 | V | 3 Housekeeping | | | | 0 | | 17 |
| 18 | V | 4 Laundry | | | | 0 | | 18 |
| 19 | V | 5 Heat & Other Utilities | | | | 2,215 | 2,215 | 19 |
| 20 | V | 6 Maintenance | | | | 17,451 | 17,451 | 20 |
| 21 | V | 7 Other | | | | 0 | | 21 |
| 22 | V | 9 Medical Director | | | | 0 | | 22 |
| 23 | V | 10 Nursing & Medical Records | | | | 0 | | 23 |
| 24 | V | 11 Activities | | | | 0 | | 24 |
| 25 | V | 12 Social Service | | | | 0 | | 25 |
| 26 | V | 13 Nurse Aide Training | | | | 3,253 | 3,253 | 26 |
| 27 | V | 14 Program Transportation | | | | 0 | | 27 |
| 28 | V | 15 Other | | | | 0 | | 28 |
| 29 | V | 17 Administrative | | | | 48,223 | 48,223 | 29 |
| 30 | V | 18 Directors Fees | | | | 7,551 | 7,551 | 30 |
| 31 | V | 19 Professional Services | | | | 18,517 | 18,517 | 31 |
| 32 | V | 20 Fees, Subscription, Promotions | | | | 7,117 | 7,117 | 32 |
| 33 | V | 21 Clerical & General Office Expenses | | | | 261,838 | 261,838 | 33 |
| 34 | V | 22 Employee Benefits & Payroll Taxes | | | | 37,167 | 37,167 | 34 |
| 35 | V | 23 Inservice Training & Education | | | | 1,426 | 1,426 | 35 |
| 36 | V | 24 Travel and Seminar | | | | 10,138 | 10,138 | 36 |
| 37 | V | 25 Other Admin. Staff Transportation | | | | 0 | | 37 |
| 38 | V | 26 Insurance-Prop.Liab.Malpract | | | | 2,674 | 2,674 | 38 |
| 39 | Total | | \$ | | | \$ 423,010 | \$ * 423,010 | 39 |

Sum_6A

5440

2215

17451

3253

48223

7551

18517

7117

261838

37167

1426

10138

2674

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | 27 Other | \$ | Heritage Enterprises, Inc. | 100.00% | \$ 0 | \$ | 15 |
| 16 | V | 30 Depreciation | | | | 11,730 | 11,730 | 16 |
| 17 | V | 31 Amortization of Pre-Op & Org | | | | 0 | | 17 |
| 18 | V | 32 Interest | | | | (150) | (150) | 18 |
| 19 | V | 33 Real Estate Taxes | | | | 0 | | 19 |
| 20 | V | 34 Rent-Facility & Grounds | | | | 12,502 | 12,502 | 20 |
| 21 | V | 35 Rent-Equipment & Vehicles | | | | 26,110 | 26,110 | 21 |
| 22 | V | 36 Other | | | | 0 | | 22 |
| 23 | V | 38 Medically Nec Transportation | | | | 0 | | 23 |
| 24 | V | 39 Ancillary Service Centers | | | | 0 | | 24 |
| 25 | V | 40 Barber and Beauty Shops | | | | 0 | | 25 |
| 26 | V | 41 Coffee and Gift Shops | | | | 0 | | 26 |
| 27 | V | 42 Other | | | | 0 | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ 50,192 | \$ * 50,192 | 39 |

Sum_6B

11730

-150

12502

26110

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
|------------|-------|-------------------------|-------------------------------------|------------------------------|----------------------------|--|--|----|
| Schedule V | Line | Cost Per General Ledger | Amount | Cost to Related Organization | Percent of Ownership | Operating Cost of Related Organization | Difference: Adjustments for Related Organization Costs (7 minus 4) | |
| 15 | V | 19 | Adjustment for Related Organization | \$ 340,740 | Heritage Enterprises, Inc. | \$ | (340,740) | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | 10a | Adjustment for Related Organization | 465,738 | Green Tree Pharmacy | 100.00% | 659,589 | 17 |
| 18 | V | | | | | | 193,851 | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ 806,478 | | | \$ 659,589 | \$ * (146,889) | 39 |

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6C

-340740

193851

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6D

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6E

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6E

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6F

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6F

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6G

* Total must agree with the amount recorded on line 34 of Schedule VI.

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6H

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6H

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6I

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: Adjustments for Related Organization Costs (7 minus 4) | |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|----|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | | |
| 15 | V | | \$ | | | \$ | \$ | 15 |
| 16 | V | | | | | | | 16 |
| 17 | V | | | | | | | 17 |
| 18 | V | | | | | | | 18 |
| 19 | V | | | | | | | 19 |
| 20 | V | | | | | | | 20 |
| 21 | V | | | | | | | 21 |
| 22 | V | | | | | | | 22 |
| 23 | V | | | | | | | 23 |
| 24 | V | | | | | | | 24 |
| 25 | V | | | | | | | 25 |
| 26 | V | | | | | | | 26 |
| 27 | V | | | | | | | 27 |
| 28 | V | | | | | | | 28 |
| 29 | V | | | | | | | 29 |
| 30 | V | | | | | | | 30 |
| 31 | V | | | | | | | 31 |
| 32 | V | | | | | | | 32 |
| 33 | V | | | | | | | 33 |
| 34 | V | | | | | | | 34 |
| 35 | V | | | | | | | 35 |
| 36 | V | | | | | | | 36 |
| 37 | V | | | | | | | 37 |
| 38 | V | | | | | | | 38 |
| 39 | Total | | \$ | | | \$ | \$ * | 39 |

Sum_6I

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

| | 1 Name | 2 Title | 3 Function | 4 Ownership Interest | 5 Compensation Received From Other Nursing Homes* | 6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week | | 7 Compensation Included in Costs for this Reporting Period** | | 8 Schedule V. Line & Column Reference | |
|----|----------------------------|------------|---------------|-------------------------|--|--|---------|---|----------|--|----|
| | | | | | | Hours | Percent | Description | Amount | | |
| 1 | Heritage Enterprises, Inc. | | | 0.50 | | | | | \$ 7,551 | line 18, col 7 | 1 |
| 2 | Memorial Health Ventures | | | 0.50 | | | | | | | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ 7,551 | | 13 |

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01Ending: **12/31/01**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|-----------------------------------|--|------------------|---|--|--|------------------------|---|----|
| 1 | 1 | Dietary | BEDS | 2,328 | 23 | \$ 71,961 | \$ 71,961 | 176 | \$ 5,440 | 1 |
| 2 | 2 | Food Purchase | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 2 |
| 3 | 3 | Housekeeping | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 3 |
| 4 | 4 | Laundry | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 4 |
| 5 | 5 | Heat & Other Utilities | BEDS | 2,328 | 23 | 29,301 | 0 | 176 | 2,215 | 5 |
| 6 | 6 | Maintenance | BEDS | 2,328 | 23 | 230,824 | 54,124 | 176 | 17,451 | 6 |
| 7 | 7 | Other | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 7 |
| 8 | 9 | Medical Director | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 8 |
| 9 | 10 | Nursing & Medical Records | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 9 |
| 10 | 11 | Activities | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 10 |
| 11 | 12 | Social Service | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 11 |
| 12 | 13 | Nurse Aide Training | BEDS | 2,328 | 23 | 43,025 | 0 | 176 | 3,253 | 12 |
| 13 | 14 | Program Transportation | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 13 |
| 14 | 15 | Other | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 14 |
| 15 | 17 | Administrative | BEDS | 2,328 | 23 | 637,854 | 637,854 | 176 | 48,223 | 15 |
| 16 | 18 | Directors Fees | BEDS | 2,328 | 23 | 99,885 | 0 | 176 | 7,551 | 16 |
| 17 | 19 | Professional Services | BEDS | 2,328 | 23 | 244,928 | 0 | 176 | 18,517 | 17 |
| 18 | 20 | Fees, Subscription, Promotions | BEDS | 2,328 | 23 | 94,145 | 0 | 176 | 7,117 | 18 |
| 19 | 21 | Clerical & General Office Expense | BEDS | 2,328 | 23 | 3,463,403 | 3,114,857 | 176 | 261,838 | 19 |
| 20 | 22 | Employee Benefits & Payroll Tax | BEDS | 2,328 | 23 | 491,614 | 0 | 176 | 37,167 | 20 |
| 21 | 23 | Inservice Training & Education | BEDS | 2,328 | 23 | 18,866 | 0 | 176 | 1,426 | 21 |
| 22 | 24 | Travel and Seminar | BEDS | 2,328 | 23 | 134,093 | 0 | 176 | 10,138 | 22 |
| 23 | 25 | Other Admin. Staff Transportation | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 23 |
| 24 | 26 | Insurance-Prop.Liab.Malpract | BEDS | 2,328 | 23 | 35,366 | 0 | 176 | 2,674 | 24 |
| 25 | TOTALS | | | | | \$ 5,595,265 | \$ 3,878,796 | | \$ 423,010 | 25 |

Print Preview

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01

Ending:

12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|--|--------------------------------------|---------------------------------|---|----------------------|---|--|--|------------------------|---|----|
| | 1 | 27 Other | BEDS | 2,328 | 23 | \$ 0 | \$ 0 | 176 | \$ 0 | 1 |
| | 2 | 30 Depreciation | BEDS | 2,328 | 23 | 155,150 | 0 | 176 | 11,730 | 2 |
| | 3 | 31 Amortization of Pre-Op & Org | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 3 |
| | 4 | 32 Interest | BEDS | 2,328 | 23 | (1,990) | 0 | 176 | (150) | 4 |
| | 5 | 33 Real Estate Taxes | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 5 |
| | 6 | 34 Rent-Facility & Grounds | BEDS | 2,328 | 23 | 165,362 | 0 | 176 | 12,502 | 6 |
| | 7 | 35 Rent-Equipment & Vehicles | BEDS | 2,328 | 23 | 345,363 | 0 | 176 | 26,110 | 7 |
| | 8 | 36 Other | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 8 |
| | 9 | 38 Medically Nec Transportation | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 9 |
| | 10 | 39 Ancillary Service Centers | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 10 |
| | 11 | 40 Barber and Beauty Shops | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 11 |
| | 12 | 41 Coffee and Gift Shops | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 12 |
| | 13 | 42 Other | BEDS | 2,328 | 23 | 0 | 0 | 176 | 0 | 13 |
| | 14 | | | | | | | | | 14 |
| | 15 | | | | | | | | | 15 |
| | 16 | | | | | | | | | 16 |
| | 17 | | | | | | | | | 17 |
| | 18 | | | | | | | | | 18 |
| | 19 | | | | | | | | | 19 |
| | 20 | | | | | | | | | 20 |
| | 21 | | | | | | | | | 21 |
| | 22 | | | | | | | | | 22 |
| | 23 | | | | | | | | | 23 |
| | 24 | | | | | | | | | 24 |
| | 25 | TOTALS | | | | \$ 663,885 | \$ | | \$ 50,192 | 25 |

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01

Ending:

12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|---------------|---|----------------------|---|--|--|----------------------------|---|----|
| 1 | | | | | | \$ | \$ | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ | \$ | | \$ | 25 |

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01

Ending:

12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|---------------|---|------------------|---|--|--|------------------------|---|----|
| 1 | | | | | | \$ | \$ | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ | \$ | | \$ | 25 |

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01

Ending:

12/31/01**VIII. ALLOCATION OF INDIRECT COSTS**

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---------------------------------|--------|--|-------------|--|---|---|-------------------|------------------------------------|----|
| Schedule V Line Reference | Item | Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | Total Units | Number of Subunits Being Allocated Among | Total Indirect Cost Being Allocated | Amount of Salary Cost Contained in Column 6 | Facility Units | Allocation (col.8/col.4)x col.6 | |
| 1 | | | | | \$ | \$ | | \$ | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ | \$ | | \$ | 25 |

Facility Name & ID Number **HERITAGE MANOR-SPRINGFIELD**# **0041699**

Report Period Beginning:

01/01/01

Ending:

12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|---------------|---|----------------------|---|--|--|----------------------------|---|----|
| 1 | | | | | | \$ | \$ | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ | \$ | | \$ | 25 |

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

| | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 | 8 | 9 | 10 | |
|----|-----------------------------------|-----------|----|-----------------|--------------------------|--------------|----------------|--------------|---------------|--------------------------|-----------------------------------|----|--|
| | Name of Lender | Related** | | Purpose of Loan | Monthly Payment Required | Date of Note | Amount of Note | | Maturity Date | Interest Rate (4 Digits) | Reporting Period Interest Expense | | |
| | | YES | NO | | | | Original | Balance | | | | | |
| | A. Directly Facility Related | | | | | | | | | | | | |
| | Long-Term | | | | | | | | | | | | |
| 1 | Mercantile Bank | | XX | Mortgage | \$19,269.00 | 01/15/99 | \$ 3,400,000 | \$ 2,910,627 | 01/15/04 | variable | \$ 168,722 | 1 | |
| 2 | Mercantile Bank Loan Amortization | | XX | Mortgage | | | | | | | 2,182 | 2 | |
| 3 | Central Office Allocation | | XX | Interest Income | | | | | | | (150) | 3 | |
| 4 | | | | | | | | | | | | 4 | |
| 5 | | | | | | | | | | | | 5 | |
| | Working Capital | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | 6 | |
| 7 | Mercantile Bank working Capital | | | | | | | 250,000 | | | 1,117 | 7 | |
| 8 | | | | | | | | | | | | 8 | |
| 9 | TOTAL Facility Related | | | | \$19,269.00 | | \$ 3,400,000 | \$ 3,160,627 | | | \$ 171,871 | 9 | |
| | B. Non-Facility Related* | | | | | | | | | | | | |
| 10 | Interest Income | | | | | | | | | | 14,265 | 10 | |
| 11 | | | | | | | | | | | | 11 | |
| 12 | | | | | | | | | | | | 12 | |
| 13 | | | | | | | | | | | | 13 | |
| 14 | TOTAL Non-Facility Related | | | | | | \$ | \$ | | | \$ 14,265 | 14 | |
| 15 | TOTALS (line 9+line14) | | | | | | \$ 3,400,000 | \$ 3,160,627 | | | \$ 157,606 | 15 | |

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)
** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Print Preview

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

**Hold down
Control Key and hit r**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-SPRINGFIELD COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT CRAIG L. ATER

TELEPHONE (309)823-7135 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

| (A) | (B) | (C) | (D) |
|--------------------------------|---|--------------------------|---|
| <u>Tax Index Number</u> | <u>Property Description</u> | <u>Total Tax</u> | <u>Tax Applicable to Nursing Home</u> |
| 1. <u>14280277027</u> | <u>HERITAGE MANOR-SPRINGFIE</u> | \$ <u>104,428</u> | \$ <u>104,428</u> |
| 2. <u> </u> | <u>HERITAGE MANOR-SPRINGFIE</u> | \$ <u>0</u> | \$ <u>0</u> |
| 3. <u> </u> | <u> </u> | \$ <u>0</u> | \$ <u>0</u> |
| 4. <u> </u> | <u> </u> | \$ <u>0</u> | \$ <u> </u> |
| 5. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| 6. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| 7. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| 8. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| 9. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| 10. <u> </u> | <u> </u> | \$ <u> </u> | \$ <u> </u> |
| TOTALS | | \$ <u><u>104,428</u></u> | \$ <u><u>104,428</u></u> |

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

| | | | | | |
|------------------------|---------------|--------------------------------------|-----------------|--------------|--------------------------|
| A. Square Feet: | 33,800 | B. General Construction Type: | Exterior | Frame | Number of Stories |
|------------------------|---------------|--------------------------------------|-----------------|--------------|--------------------------|

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.). List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

| | 1 | 2 | 3 | 4 | |
|---|--------------|-------------|---------------|------------|---|
| | Use | Square Feet | Year Acquired | Cost | |
| 1 | Nursing Home | | 1996 | \$ 630,000 | 1 |
| 2 | Nursing Home | | | | 2 |
| 3 | TOTALS | | | \$ 630,000 | 3 |

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 | FOR OHF USE ONLY | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|----|--------------------|------------------|------------------|---------------------|--------------|------------------------------|------------------|-------------------------------|-------------|-----------------------------|----|
| | Beds* | | Year Acquired | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | |
| 4 | 176 | | | | \$ 1,870,000 | \$ | | \$ | \$ | \$ | 4 |
| 5 | | | | | 1,648,258 | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | Improvement Type** | | | | | | | | | | |
| 9 | 1985 Improvements | | | 1985 | 26,076 | | | | | | 9 |
| 10 | 1986 Improvements | | | 1986 | 216,545 | | | | | | 10 |
| 11 | 1987 Improvements | | | 1987 | 593,121 | | | | | | 11 |
| 12 | 1988 Improvements | | | 1988 | 29,321 | | | | | | 12 |
| 13 | 1989 Improvements | | | 1989 | 1,095 | | | | | | 13 |
| 14 | 1990 Improvements | | | 1990 | 939 | | | | | | 14 |
| 15 | 1991 Improvements | | | 1991 | 32,022 | | | | | | 15 |
| 16 | 1992 Improvements | | | 1992 | 32,593 | | | | | | 16 |
| 17 | 1993 Improvements | | | 1993 | 105,986 | | | | | | 17 |
| 18 | 1994 Improvements | | | 1994 | 59,542 | | | | | | 18 |
| 19 | 1995 Improvements | | | 1995 | 36,126 | | | | | | 19 |
| 20 | Laundry Chute | | | 1996 | 4,926 | | | | | | 20 |
| 21 | Door Alarm | | | 1996 | 8,533 | | | | | | 21 |
| 22 | Garbage Disposal | | | 1996 | 1,113 | | | | | | 22 |
| 23 | Elevator | | | 1996 | 11,439 | | | | | | 23 |
| 24 | | | | | | | | | | | 24 |
| 25 | | | | | | | | | | | 25 |
| 26 | | | | | | | | | | | 26 |
| 27 | | | | | | | | | | | 27 |
| 28 | | | | | | | | | | | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | C/O Allocation | | | | | | | 11,730 | 11,730 | | 34 |
| 35 | Book Depreciation | | | | | 139,874 | | 139,874 | | 1,473,506 | 35 |
| 36 | | | | | 4,677,635 | | | | | | 36 |

^ Total beds on this schedule must agree with page 4.

See page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

0041699

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| 1 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---|------------------|------------|---------------------------|---------------|----------------------------|-------------|--------------------------|----|
| Improvement Type** | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | |
| 37 Vent Shaft | 1997 | 6,267 | | | | | | 37 |
| 38 Fire Dampers | 1997 | 510 | | | | | | 38 |
| 39 Computer Cabling | 1997 | 14,518 | | | | | | 39 |
| 40 Rehab Therapy Room | 1997 | 7,391 | | | | | | 40 |
| 41 Air Conditioner--Chiller | 1997 | 47,954 | | | | | | 41 |
| 42 Remodel First Floor | 1997 | 27,570 | | | | | | 42 |
| 43 | | | | | | | | 43 |
| 44 Landscape | 1998 | 2,410 | | | | | | 44 |
| 45 Vent Work | 1998 | 7,018 | | | | | | 45 |
| 46 Asphalt Ramp | 1998 | 850 | | | | | | 46 |
| 47 Room Remodel | 1998 | 1,142 | | | | | | 47 |
| 48 | | | | | | | | 48 |
| 49 Code Alert | 1999 | 7,829 | | | | | | 49 |
| 50 Wall Paper | 1999 | 704 | | | | | | 50 |
| 51 Remodel Office Interior | 1999 | 1,248 | | | | | | 51 |
| 52 Elevator Repair | 1999 | 2,697 | | | | | | 52 |
| 53 Carpet | 1999 | 1,097 | | | | | | 53 |
| 54 | | | | | | | | 54 |
| 55 Shed Yardmate | 2000 | 522 | | | | | | 55 |
| 56 A/C Rooftop Unit | 2000 | 2,937 | | | | | | 56 |
| 57 Sewerline Repair | 2000 | 1,482 | | | | | | 57 |
| 58 | | | | | | | | 58 |
| 59 Facility Renovation--Materials | 2001 | 745,911 | | | | | | 59 |
| 60 Facility Renovation--Labor | 2001 | 1,463 | | | | | | 60 |
| 61 Facility Renovation--Interior Design | 2001 | 69,313 | | | | | | 61 |
| 62 Fire Alarm System | 2001 | 8,718 | | | | | | 62 |
| 63 Sewer Line Repair | 2001 | 1,787 | | | | | | 63 |
| 64 | | | | | | | | 64 |
| 65 Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident | | | | | | | | 65 |
| 66 rooms including hallways and common areas | | | | | | | | 66 |
| 67 | | | | | | | | 67 |
| 68 | | | | | | | | 68 |
| 69 | | | | | | | | 69 |
| 70 TOTAL (lines 4 thru 69) | | \$ 961,338 | \$ 139,874 | | \$ 151,604 | \$ 11,730 | \$ 1,473,506 | 70 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

STATE OF ILLINOIS

0041699

Report Period Beginning:

01/01/01 Ending:

Page 12B

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

| 1 Improvement Type** | | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|-------------------------|---------------------------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 1 | Totals from Page 12A, Carried Forward | | \$ 961,338 | \$ 0 | | \$ 0 | \$ | \$ 1,473,506 | 1 |
| 2 | | | | | | | | | 2 |
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| 31 | | | | | | | | | 31 |
| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 961,338 | \$ 0 | | \$ 0 | \$ 0 | \$ 1,473,506 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

STATE OF ILLINOIS

0041699

Report Period Beginning:

01/01/01 Ending:

Page 12C

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

| 1 Improvement Type** | | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|-------------------------|---------------------------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 1 | Totals from Page 12B, Carried Forward | | \$ 961,338 | \$ 0 | | \$ 0 | \$ | \$ 1,473,506 | 1 |
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| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 961,338 | \$ 0 | | \$ 0 | \$ 0 | \$ 1,473,506 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

STATE OF ILLINOIS

0041699

Report Period Beginning:

01/01/01 Ending:

Page 12D

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

| 1 Improvement Type** | | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|-------------------------|---------------------------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 1 | Totals from Page 12C, Carried Forward | | \$ 961,338 | \$ 0 | | \$ 0 | \$ | \$ 1,473,506 | 1 |
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| 32 | | | | | | | | | 32 |
| 33 | | | | | | | | | 33 |
| 34 | TOTAL (lines 1 thru 33) | | \$ 961,338 | \$ 0 | | \$ 0 | \$ 0 | \$ 1,473,506 | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD
XI. OWNERSHIP COSTS (continued)

STATE OF ILLINOIS
0041699

Report Period Beginning: 01/01/01 Ending: 12/31/01

Page 12E

To Print this page only

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down
Control Key and hit t

| 1 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---|---------------------|------------|------------------------------|------------------|-------------------------------|-------------|-----------------------------|----|
| Improvement Type** | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | |
| 1 Totals from Page I2D, Carried Forward | | \$ 961,338 | \$ 0 | | \$ 0 | | \$ ##### | 1 |
| 2 | | | | | | | | 2 |
| 3 | | | | | | | | 3 |
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| 32 | | | | | | | | 32 |
| 33 | | | | | | | | 33 |
| 34 TOTAL (lines 1 thru 33) | | \$ 961,338 | \$ 0 | | \$ 0 | \$ 0 | \$ ##### | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Hold down

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Control Key and hit w

| 1 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---|---------------------|------------|------------------------------|------------------|-------------------------------|-------------|-----------------------------|----|
| Improvement Type** | Year Constructed | Cost | Current Book Depreciation | Life in Years | Straight Line Depreciation | Adjustments | Accumulated Depreciation | |
| 1 Totals from Page 12E, Carried Forward | | \$ 961,338 | \$ 0 | | \$ 0 | | \$ ##### | 1 |
| 2 | | | | | | | | 2 |
| 3 | | | | | | | | 3 |
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| 31 | | | | | | | | 31 |
| 32 | | | | | | | | 32 |
| 33 | | | | | | | | 33 |
| 34 TOTAL (lines 1 thru 33) | | \$ 961,338 | \$ 0 | | \$ 0 | \$ 0 | \$ ##### | 34 |

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD # 0041699 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

| | Category of Equipment | 1 Cost | Current Book Depreciation 2 | Straight Line Depreciation 3 | 4 Adjustments | Component Life 5 | Accumulated Depreciation 6 | |
|----|--------------------------|--------------|-----------------------------|------------------------------|------------------|------------------|----------------------------|----|
| 71 | Purchased in Prior Years | \$ 990,510 | \$ 73,816 | \$ 73,816 | \$ | | \$ 818,448 | 71 |
| 72 | Current Year Purchases | 148,091 | | | | | | 72 |
| 73 | Fully Depreciated Assets | | | | | | | 73 |
| 74 | | | | | | | | 74 |
| 75 | TOTALS | \$ 1,138,601 | \$ 73,816 | \$ 73,816 | \$ | | \$ 818,448 | 75 |

D. Vehicle Depreciation (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|----|----------|------------------------|-----------------|-----------|-----------------------------|------------------------------|------------------|-----------------|----------------------------|----|
| 76 | | | | \$ | \$ | \$ | \$ | | \$ | 76 |
| 77 | | | | | | | | | | 77 |
| 78 | | | | | | | | | | 78 |
| 79 | | | | | | | | | | 79 |
| 80 | TOTALS | | | \$ | \$ | \$ | \$ | | \$ | 80 |

E. Summary of Care-Related Assets

| | 1 Reference | 2 Amount | |
|----|--|--------------|----|
| 81 | Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable) | \$ 7,407,574 | 81 |
| 82 | Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable) | \$ 213,690 | 82 |
| 83 | Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable) | \$ 225,420 | 83 |
| 84 | Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable) | \$ 11,730 | 84 |
| 85 | Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable) | \$ 2,291,954 | 85 |

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

| | 1 Description & Year Acquired | 2 Cost | Current Book Depreciation 3 | Accumulated Depreciation 4 | |
|----|----------------------------------|-----------|-----------------------------|----------------------------|----|
| 86 | | \$ | \$ | \$ | 86 |
| 87 | | | | | 87 |
| 88 | | | | | 88 |
| 89 | | | | | 89 |
| 90 | | | | | 90 |
| 91 | TOTALS | \$ | \$ | \$ | 91 |

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------|----|
| 92 | | \$ | 92 |
| 93 | | | 93 |
| 94 | | | 94 |
| 95 | | \$ | 95 |

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

| | | 1 Year Constructed | 2 Number of Beds | 3 Date of Lease | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|--------------------|--------------------------|------------------------|-----------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: | | | | \$ 0 | | | 3 |
| 4 | Additions | | | | | | | 4 |
| 5 | | | | | | | | 5 |
| 6 | | | | | | | | 6 |
| 7 | TOTAL | | | | \$ ** | | | 7 |

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☒ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 28,825

Description: Copier, Cell Phone and Central Office Allocation

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

| | 1 Use | 2 Model Year and Make | 3 Monthly Lease Payment | 4 Rental Expense for this Period | |
|----|----------|-----------------------------|-------------------------------|--|----|
| 17 | | | \$ | \$ | 17 |
| 18 | | | | | 18 |
| 19 | | | | | 19 |
| 20 | | | | | 20 |
| 21 | TOTAL | | \$ | \$ | 21 |

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending

Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

#

0041699

Report Period Beginning:

01/01/01

Ending:

12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES
☐ NO2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

B. EXPENSES

ALLOCATION OF COSTS

(d)

| | | 1 | 2 | 3 | 4 |
|----|---------------------------------|-----------|-----------|----------|--------|
| | | Facility | | | |
| | | Drop-outs | Completed | Contract | Total |
| 1 | Community College Tuition | \$ | | \$ | \$ |
| 2 | Books and Supplies | | 671 | | 671 |
| 3 | Classroom Wages (a) | | 0 | | |
| 4 | Clinical Wages (b) | | | | |
| 5 | In-House Trainer Wages (c) | | 0 | | |
| 6 | Transportation | | | | |
| 7 | Contractual Payments | | | | |
| 8 | Nurse Aide Competency Tests | | | | |
| 9 | TOTALS | \$ | \$ 671 | \$ | \$ 671 |
| 10 | SUM OF line 9, col. 1 and 2 (e) | \$ | 671 | | |

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

| COMPLETED | |
|------------------------------|--|
| 1. From this facility | |
| 2. From other facilities (f) | |
| DROP-OUTS | |
| 1. From this facility | |
| 2. From other facilities (f) | |
| TOTAL TRAINED | |

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

| 1 | | 2 | | 3 | 4 | 5 | 6 | 7 | 8 | |
|----|--|--|---------------------|------|---|---------------------------------|--------------------------------------|-------------------------------|--------------------------------|----|
| | Service | Schedule V Line & Column Reference | Staff | | Outside Practitioner (other than consultant) | | Supplies (Actual or Allocated) | Total Units (Column 2 + 4) | Total Cost (Col. 3 + 5 + 6) | |
| | | | Units of Service | Cost | Units | Cost | | | | |
| | | | | | 1 | Licensed Occupational Therapist | 10a/3 | hrs | \$ | |
| 2 | Licensed Speech and Language Development Therapist | 10a/3 | hrs | | | 22,114 | | | 22,114 | 2 |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | 3 |
| 4 | Licensed Physical Therapist | 10a/3 | hrs | | | 218,390 | 3,867 | | 222,257 | 4 |
| 5 | Physician Care | | visits | | | | | | | 5 |
| 6 | Dental Care | | visits | | | | | | | 6 |
| 7 | Work Related Program | | hrs | | | | | | | 7 |
| 8 | Habilitation | | hrs | | | | | | | 8 |
| 9 | Pharmacy | 39/3 | # of prescripts | | | | 659,589 | | 659,589 | 9 |
| 10 | Psychological Services (Evaluation and Diagnosis/ Behavior Modification) | | hrs | | | | | | | 10 |
| 11 | Academic Education | | hrs | | | | | | | 11 |
| 12 | Exceptional Care Program | | | | | | | | | 12 |
| 13 | Other (specify): | 39/3 | | | | 14,463 | | | 14,463 | 13 |
| 14 | TOTAL | | | \$ | | \$ 398,484 | \$ 663,456 | | \$ 1,061,940 | 14 |

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

pt adj 50486
 st adj 9859
 Ot adj 57957

 drugs 193852

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

| | | 1 Operating | 2 After Consolidation* | |
|----|---|----------------|---------------------------|----|
| | A. Current Assets | | | |
| 1 | Cash on Hand and in Banks | \$ 98,354 | \$ | 1 |
| 2 | Cash-Patient Deposits | 20,843 | | 2 |
| 3 | Accounts & Short-Term Notes Receivable-Patients (less allowance) | 1,107,890 | | 3 |
| 4 | Supply Inventory (priced at) | | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 39,928 | | 6 |
| 7 | Other Prepaid Expenses | | | 7 |
| 8 | Accounts Receivable (owners or related parties) | (34,979) | | 8 |
| 9 | Other(specify): | | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 1,232,036 | \$ | 10 |
| | B. Long-Term Assets | | | |
| 11 | Long-Term Notes Receivable | | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | 630,000 | | 13 |
| 14 | Buildings, at Historical Cost | 5,668,974 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | | | 15 |
| 16 | Equipment, at Historical Cost | 1,138,601 | | 16 |
| 17 | Accumulated Depreciation (book methods) | (2,291,954) | | 17 |
| 18 | Deferred Charges | | | 18 |
| 19 | Organization & Pre-Operating Costs | | | 19 |
| | Accumulated Amortization - | | | |
| 20 | Organization & Pre-Operating Costs | | | 20 |
| 21 | Restricted Funds | | | 21 |
| 22 | Other Long-Term Assets (specify): | | | 22 |
| 23 | Other(specify): | 1,644,988 | | 23 |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | \$ 6,790,609 | \$ | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 8,022,645 | \$ | 25 |

| | | 1 Operating | 2 After Consolidation* | |
|----|--|----------------|---------------------------|----|
| | C. Current Liabilities | | | |
| 26 | Accounts Payable | \$ 272,395 | \$ | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | 20,843 | | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | 0 | | 30 |
| | Accrued Taxes Payable | | | |
| 31 | (excluding real estate taxes) | 0 | | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 109,650 | | 32 |
| 33 | Accrued Interest Payable | 7,322 | | 33 |
| 34 | Deferred Compensation | | | 34 |
| 35 | Federal and State Income Taxes | | | 35 |
| | Other Current Liabilities(specify): | | | |
| 36 | | 0 | | 36 |
| 37 | | | | 37 |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | \$ 410,210 | \$ | 38 |
| | D. Long-Term Liabilities | | | |
| 39 | Long-Term Notes Payable | | | 39 |
| 40 | Mortgage Payable | 2,910,627 | | 40 |
| 41 | Bonds Payable | | | 41 |
| 42 | Deferred Compensation | | | 42 |
| | Other Long-Term Liabilities(specify): | | | |
| 43 | | | | 43 |
| 44 | | | | 44 |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | \$ 2,910,627 | \$ | 45 |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | \$ 3,320,837 | \$ | 46 |
| 47 | TOTAL EQUITY(page 18, line 24) | \$ 4,701,808 | \$ | 47 |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | \$ 8,022,645 | \$ | 48 |

*(See instructions.)

Print Preview

| | | 1 Total | |
|----|--|--------------|------|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ 4,644,653 | 1 |
| 2 | Restatements (describe): | | 2 |
| 3 | audit Adjustment | 0 | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ 4,644,653 | 6 |
| | A. Additions (deductions): | | |
| 7 | NET Income (Loss) (from page 19, line 43) | 107,155 | 7 |
| 8 | Aquisitions of Pooled Companies | | 8 |
| 9 | Proceeds from Sale of Stock | | 9 |
| 10 | Stock Options Exercised | | 10 |
| 11 | Contributions and Grants | | 11 |
| 12 | Expenditures for Specific Purposes | | 12 |
| 13 | Dividends Paid or Other Distributions to Owners | (50,000) | 13 |
| 14 | Donated Property, Plant, and Equipment | | 14 |
| 15 | Other (describe) | | 15 |
| 16 | Other (describe) | | 16 |
| 17 | TOTAL Additions (deductions) (sum of lines 7-16) | \$ 57,155 | 17 |
| | B. Transfers (Itemize): | | |
| 18 | | | 18 |
| 19 | | | 19 |
| 20 | | | 20 |
| 21 | | | 21 |
| 22 | | | 22 |
| 23 | TOTAL Transfers (sum of lines 18-22) | \$ | 23 |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) | \$ 4,701,808 | 24 * |

* This must agree with page 17, line 47.

Print Preview

Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

0041699

Report Period Beginning: 01/01/01

Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

| 1 | | 2 | |
|-----|---|--------------|-----|
| | Revenue | Amount | |
| | A. Inpatient Care | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 7,098,605 | 1 |
| 2 | Discounts and Allowances for all Levels | (1,413,391) | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 5,685,214 | 3 |
| | B. Ancillary Revenue | | |
| 4 | Day Care | 0 | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | 725,998 | 6 |
| 7 | Oxygen | | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ 725,998 | 8 |
| | C. Other Operating Revenue | | |
| 9 | Payments for Education | | 9 |
| 10 | Other Government Grants | | 10 |
| 11 | Nurses Aide Training Reimbursements | 627 | 11 |
| 12 | Gift and Coffee Shop | 3,076 | 12 |
| 13 | Barber and Beauty Care | 5,699 | 13 |
| 14 | Non-Patient Meals | | 14 |
| 15 | Telephone, Television and Radio | | 15 |
| 16 | Rental of Facility Space | 383 | 16 |
| 17 | Sale of Drugs | 804,585 | 17 |
| 18 | Sale of Supplies to Non-Patients | | 18 |
| 19 | Laboratory | | 19 |
| 20 | Radiology and X-Ray | | 20 |
| 21 | Other Medical Services | 185 | 21 |
| 22 | Laundry | | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ 814,555 | 23 |
| | D. Non-Operating Revenue | | |
| 24 | Contributions | 0 | 24 |
| 25 | Interest and Other Investment Income*** | 14,265 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 14,265 | 26 |
| | E. Other Revenue (specify):**** | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | | 0 | 28 |
| 28a | | | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 7,240,032 | 30 |

| 1 | | 2 | |
|----|--|--------------|----|
| | Expenses | Amount | |
| | A. Operating Expenses | | |
| 31 | General Services | \$ 1,346,865 | 31 |
| 32 | Health Care | 3,780,418 | 32 |
| 33 | General Administration | 1,472,445 | 33 |
| | B. Capital Expense | | |
| 34 | Ownership | 533,149 | 34 |
| | C. Ancillary Expense | | |
| 35 | Special Cost Centers | | 35 |
| 36 | Provider Participation Fee | | 36 |
| | D. Other Expenses (specify): | | |
| 37 | Non Nursing Home Revenue/Expense | 0 | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 7,132,877 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | 107,155 | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ 107,155 | 43 |

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

| | | 1 | 2** | 3 | 4 | |
|----|-------------------------------|---------------------------------|----------------------------------|--|---------------------------|----|
| | | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage | |
| 1 | Director of Nursing | 1,872 | 2,080 | \$ 51,144 | \$ 24.59 | 1 |
| 2 | Assistant Director of Nursing | 3,934 | 4,484 | 85,253 | 19.01 | 2 |
| 3 | Registered Nurses | 24,248 | 26,059 | 527,369 | 20.24 | 3 |
| 4 | Licensed Practical Nurses | 40,177 | 46,384 | 671,536 | 14.48 | 4 |
| 5 | Nurse Aides & Orderlies | 107,552 | 114,357 | 1,244,470 | 10.88 | 5 |
| 6 | Nurse Aide Trainees | 0 | 0 | 0 | | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | 1,340 | 1,501 | 12,838 | 8.55 | 8 |
| 9 | Activity Director | | | | | 9 |
| 10 | Activity Assistants | 9,525 | 10,081 | 85,192 | 8.45 | 10 |
| 11 | Social Service Workers | 4,917 | 5,541 | 79,114 | 14.28 | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | | | | | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 38,124 | 40,959 | 356,357 | 8.70 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 16,455 | 17,746 | 153,941 | 8.67 | 17 |
| 18 | Housekeepers | 19,024 | 20,272 | 164,623 | 8.12 | 18 |
| 19 | Laundry | 10,898 | 11,811 | 103,076 | 8.73 | 19 |
| 20 | Administrator | 2,080 | 2,080 | 63,939 | 30.74 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | | | | | 23 |
| 24 | Clerical | 14,895 | 16,779 | 213,516 | 12.73 | 24 |
| 25 | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | | | | | 28 |
| 29 | Resident Services Coordinator | | | | | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | | | | | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| 33 | Other(specify) Beautician | 0 | 0 | 0 | | 33 |
| 34 | TOTAL (lines 1 - 33) | 295,041 | 320,134 | \$ 3,812,368 * | \$ 11.91 | 34 |

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

| | | 1 | 2 | 3 | |
|----|---------------------------------|--|---|---|----|
| | | Number of Hrs. Paid & Accrued | Total Consultant Cost for Reporting Period | Schedule V Line & Column Reference | |
| 35 | Dietary Consultant | | \$ | | 35 |
| 36 | Medical Director | | 15,600 | | 36 |
| 37 | Medical Records Consultant | | 0 | | 37 |
| 38 | Nurse Consultant | | | | 38 |
| 39 | Pharmacist Consultant | | 4,134 | | 39 |
| 40 | Physical Therapy Consultant | | | | 40 |
| 41 | Occupational Therapy Consultant | | | | 41 |
| 42 | Respiratory Therapy Consultant | | | | 42 |
| 43 | Speech Therapy Consultant | | | | 43 |
| 44 | Activity Consultant | | | | 44 |
| 45 | Social Service Consultant | | 2,368 | | 45 |
| 46 | Other(specify) | | | | 46 |
| 47 | | | | | 47 |
| 48 | | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | | \$ 22,102 | | 49 |

C. CONTRACT NURSES

| | | 1 | 2 | 3 | |
|----|---------------------------|--|----------------------------|---|----|
| | | Number of Hrs. Paid & Accrued | Total Contract Wages | Schedule V Line & Column Reference | |
| 50 | Registered Nurses | 302 | \$ 10,554 | | 50 |
| 51 | Licensed Practical Nurses | 1,176 | 35,277 | | 51 |
| 52 | Nurse Aides | 12 | 248 | | 52 |
| 53 | TOTAL (lines 50 - 52) | 1,490 | \$ 46,079 | | 53 |

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Facility Name & ID Number HERITAGE MANOR-SPRINGFIELD

XIX. SUPPORT SCHEDULES

| A. Administrative Salaries | | | | Ownership | |
|--|-----------------|---|------------|-----------|--|
| Name | Function | % | Amount | | |
| Vicki Bied | Administrator | | \$ 63,939 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) | | | \$ 63,939 | | |
| B. Administrative - Other | | | | | |
| Description | | | Amount | | |
| | | | \$ | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement) | | | \$ | | |
| C. Professional Services | | | | | |
| Vendor/Payee | Type | | Amount | | |
| Heritage Enterprises | Management Fees | | \$ 340,740 | | |
| All Legal is adjusted to zero | Legal | | 313 | | |
| SMS , Inc. | Reimbursement | | 5,209 | | |
| Sulaski & Webb | Audit | | 7,500 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.) | | | \$ 353,762 | | |
| D. Employee Benefits and Payroll Taxes | | | | | |
| Description | | | Amount | | |
| Workers' Compensation Insurance | | | \$ 40,492 | | |
| Unemployment Compensation Insurance | | | 24,221 | | |
| FICA Taxes | | | 291,646 | | |
| Employee Health Insurance | | | 168,957 | | |
| Employee Meals | | | | | |
| Illinois Municipal Retirement Fund (IMRF)* | | | | | |
| Employee Hepatitis Vaccine | | | 0 | | |
| Employee Benefits - | | | 20,594 | | |
| Employee Benefits - central office | | | 37,167 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL (agree to Schedule V, line 22, col.8) | | | \$ 583,077 | | |
| E. Schedule of Non-Cash Compensation Paid to Owners or Employees | | | | | |
| Description | Line # | | Amount | | |
| | | | \$ | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL | | | \$ | | |
| F. Dues, Fees, Subscriptions and Promotions | | | | | |
| Description | | | Amount | | |
| IDPH License Fee | | | \$ 200 | | |
| Advertising: Employee Recruitment | | | 10,259 | | |
| Health Care Worker Background Check (Indicate # of checks performed) | | | 812 | | |
| Central Office Allocation | | | 7,117 | | |
| Promotional Advertising | | | 4,911 | | |
| Public Relations | | | 3,029 | | |
| Dues and Subscriptions | | | 10,285 | | |
| License and Fees | | | 670 | | |
| | | | | | |
| Less: Public Relations Expense | | | (3,029) | | |
| Non-allowable advertising | | | (881) | | |
| Yellow page advertising | | | (4,911) | | |
| TOTAL (agree to Sch. V, line 20, col. 8) | | | \$ 28,462 | | |
| G. Schedule of Travel and Seminar** | | | | | |
| Description | | | Amount | | |
| Out-of-State Travel | | | \$ | | |
| | | | | | |
| | | | | | |
| In-State Travel | | | | | |
| | | | 1,598 | | |
| | | | 0 | | |
| | | | | | |
| Seminar Expense | | | 5,828 | | |
| Non Allowable | | | (15,565) | | |
| Central Office Allocation | | | 10,138 | | |
| | | | | | |
| Entertainment Expense | | | (| | |
| (agree to Sch. V, line 24, col. 8) | | | | | |
| TOTAL | | | \$ 1,999 | | |

* Attach copy of IMRF notifications

****See instructions.**

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 |
|----|---------------------|---|------------|----------------|--------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|
| | Improvement Type | Month & Year Improvement Was Made | Total Cost | Useful Life | Amount of Expense Amortized Per Year | | | | | | | | |
| | | | | | FY1997 | FY1998 | FY1999 | FY2000 | FY2001 | FY2002 | FY2003 | FY2004 | FY2005 |
| 1 | | | \$ | | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | |
| 20 | TOTALS | | \$ | | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 96,360
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 7,717
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
**g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. **Not complete as of the filing date.**
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

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